



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

COPY

C.L. BUTCH OTTER, GOVERNOR  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-6626  
FAX 208-364-1888

January 12, 2009

Noreen Davis  
St Lukes Regional Medical Center (RMC)  
Home Care  
190 East Bannock  
Boise, ID 83712

RE: St Lukes RMC Home Care, provider #137028

Dear Ms. Davis:

This is to advise you of the findings of the Validation survey at St Lukes RMC Home Care which was concluded on December 18, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Noreen Davis  
January 12, 2009  
Page 2 of 2

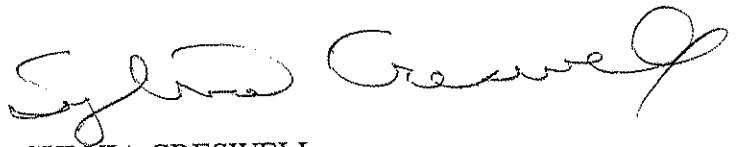
After you have completed your Plan of Correction, return the original to this office by **January 26, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sylvia Creswell for".

PATRICIA O'HARA  
Health Facility Surveyor  
Non-Long Term Care

A handwritten signature in cursive script, appearing to read "Sylvia Creswell".

SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

PO/mlw

Enclosures



January 21, 2009

Patricia O'Hara  
Health Facility Surveyor

Sylvia Cresswell  
Co-Supervisor

Non-Long Term Care  
Bureau of Facility Standards  
Idaho Department of Health and Welfare  
P.O. Box 83720  
Boise, Idaho 83720-0036

RE: St. Luke's Home Care Services provider #13028

Dear Ms. O'Hara and Ms. Cresswell:

Enclosed is our Plan of Correction for our Validation survey concluded on December 18, 2008. Because we are a Joint Commission accredited organization and currently have deemed status, we understand that a Plan of Correction is not required. However, we have determined it appropriate to respond to the deficiencies cited with an action plan.

We appreciated the professionalism and courtesy of the surveyors. If you have any questions, please call Mary Lou Long, Director, at 381-3946.

Sincerely,

A handwritten signature in cursive script, appearing to read "Noreen Davis".

Noreen Davis, RN, MBA, MPH, NE-BC  
System Vice President, Nursing and Patient Care  
St. Luke's Health System

RECEIVED

JAN 22 2009

FACILITY STANDARDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/09/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST LUKES RMC HOME CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 WEST IDAHO BOISE, ID 83712</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during a recent validation survey of your home health agency.</p> <p>The surveyors conducting the recertification were:</p> <p>Patricia O'Hara RN, HFS, Team Leader Patrick Henderson, RN, HFS Teresa Hamblin RN, MS, HFS</p> <p>Acronyms used in this report:</p> <p>BG - Blood Glucose CHF - Congestive Heart Failure HHA - Home Health Agency MSW - Master Social Work POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SOC - Start of Care SN - Skilled Nursing SW - Social Work or Social Worker</p>	G 000	<p><b>RECEIVED</b></p> <p><b>JAN 22 2009</b></p> <p><b>FACILITY STANDARDS</b></p>	
G 144	<p><b>484.14(g) COORDINATION OF PATIENT SERVICES</b></p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the HHA failed to ensure the clinical record reflected effective reporting and coordination of patient care in 1 of 19 patients (#10), whose records were reviewed. This resulted in a lack of clarity as</p>	G 144	<p>G 144 and N 062 and N 098</p> <p>Staff education regarding reporting guidelines for diabetes was done in McCall and Boise. Staff will notify the physician of blood sugars &lt;60 and &gt;300. The blood sugar ranges will be added to the plan of care. As part of the follow-up with Joint Commission, chart audits will be done.</p>	<p>✓</p> <p>Education in Boise 1/12/09 and 1/13/09 and McCall 1/8/09. Audits start 1/26/09</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Mary Lou Sorey* *Director Home Care - HFS* *1/21/09*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	<p>Continued From page 1</p> <p>to whether the agency communicated potentially significant clinical information to the physician, allowing the physician to update the POC and potentially prevent an unnecessary urgent care visit. Findings include:</p> <p>Patient #10 was admitted to the HHA on 6/11/08 primarily for care related to congestive heart failure. She also received insulin injections to help manage diabetes. Two nursing notes, dated 6/11/08 and 6/25/08, documented low blood sugar levels. According to the National Diabetes Information Clearinghouse, the normal ranges for blood glucose levels are 70-120. The nursing note, dated 6/11/08 stated the daughter reported the patient's blood sugar as 44 at 9:00 AM that morning. The nursing note, dated 6/25/08 documented results from a blood sugar log that included readings of 56, 48, 50, and 67 within the previous 4 days. The clinical record failed to document SN reported the low blood sugar readings to the physician.</p> <p>Another nursing note, dated 7/10/08, documented that the daughter reported she had transported the patient to an urgent care center two weeks prior because of concerns about the patient's low blood sugars. The nursing note also documented the Lantus insulin dosage had been reduced from 23 units to 15 units. It is unclear by the charting who changed the insulin dosage, whether it was the primary care physician, the urgent care center, the patient, or the daughter. There was no documentation in the clinical record that SN communicated to the physician information about the urgent care center visit or the change in insulin dosage.</p> <p>During a telephone interview on 12/17/08 at 11:00</p>	G 144			

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G 144	Continued From page 2 AM, the Clinical Nurse Supervisor (based in the McCall office) reviewed the clinical record for Patient #10 and responded to surveyor questions. She stated SN communicated clinical findings (blood sugar readings) to the physician for the SN visits on 6/11/08 and 6/25/08 but failed to document the communication to the physician. The clinical supervisor also stated she was not sure whether SN communicated findings from the visit on 7/10/08 to the physician. She confirmed that the clinical record lacked documentation to indicate SN had notified the physician.	G 144			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.  This STANDARD is not met as evidenced by: Based on interview and review of clinical records and agency policies and procedures, it was determined the HHA failed to ensure staff followed a written plan of care in 3 of 19 patients (#8, #9, and #10) whose records were reviewed. This resulted in missed or delayed visits that were not reported to the physician. It also resulted in clinical information not being reported to the physician that could have impacted the physician's plan of care. Findings include:  1. Patient #8 was admitted to the HHA on 11/22/08 for care related to cellulitis of the left leg	G 158	G 158 and N 152 McCall office has developed a process to track missed visits and to notify the physician. As stated in the action plan for G-144, a process for notification to the physician of abnormal blood sugars has been developed. Per our policy "Assessment, Implementation and Documentation" any time any discipline can not meet the timelines to begin care they will notify the physician. Per our Joint Commission action plan, chart audits will be done.		Education in McCall was 1/8/09 and in Boise, 1/12 and 1/13/09. Audits start 1/26/09.

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G 158	<p>Continued From page 3</p> <p>and diabetes. The POC, dated 11/22/08, called for SN visits daily between 11/23/08 and 12/11/08. Record review indicated that SN failed to make four visits during this time frame (11/26/08, 12/3/08, 12/10/08, 12/11/08) and failed to notify the physician of the missed visits. During an interview on 12/15/08 at 3:45 PM, the Clinical Nurse Specialist reviewed the record, confirmed the missed visits, and stated that two of the missed visits (11/16/08 and 12/3/08) occurred because the patient had physician appointments. She stated the nurse was new to the agency and did not realize she had to contact the physician about the missed visits under those circumstances. The clinical nurse specialist further stated that she did not know why SN missed visits on 12/10/08 and 12/11/08.</p> <p>Patient #8's POC, dated 11/22/08, included having SN assess, record, and report the patient's blood glucose levels and assess for signs and symptoms of hypo/hyperglycemia (low blood sugar and high blood sugar). There were no specific BG parameters listed on the POC for reporting. A nursing note, dated 12/8/08 documented a blood glucose level as low as 53. According to the National Diabetes Information Clearinghouse, the normal ranges for blood glucose levels are 70-120. The nursing note also documented the patient reported "getting symptomatic of hypoglycemia" (low blood sugar) especially when his blood glucose reading was 53. The specific symptoms were not described in the note. There was no documentation found in the clinical record to indicate that SN reported to the physician the low blood sugar level or the symptoms of hypoglycemia. During an interview on 12/16/08 at 8:38 AM, the Clinical Nurse Specialist stated that it would have been</p>	G 158			

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G 158	<p>Continued From page 4</p> <p>appropriate for the nurse to report the blood glucose level of 53 and the symptoms of hypoglycemia. She also confirmed the clinical record lacked documentation that SN reported the information.</p> <p>2. Patient #10 was admitted to the HHA on 6/11/08 for care related to congestive heart failure. She received SN and PT services. The POC, dated 6/11/08, included orders for one nursing visit during the week of 6/29/08 and three PT visits during the week of 6/15/08. Results of record review indicated that SN missed the visit during the week of 6/29/08 and PT missed one of the three ordered visits during the week of 6/15/08. During a telephone interview on 12/17/08 at 11:00 AM, the McCall based Clinical Nurse Supervisor confirmed the missed visits and lack of documentation that the physician had been notified. She stated she was not certain as to the reasons for the missed visits. She speculated the missed visits were not reported to the physician because the agency had been transitioning from paper charting to electronic charting and staff was experiencing a learning curve.</p> <p>3. Patient #9 was a 58-year-old female with a SOC date of 7/28/07. She was admitted to the HHA for medical management of CHF and renal disease. The patient's record contained a physician's order dated 7/17/08, requesting a MSW consult due to depression. The agency's "Assessment, Implementation and Documentation" policy, dated 04/21/08, stating "The social worker's responsibility for providing social services will be to...The initial visit will be within five working days of the contact unless patient condition dictates otherwise." The record</p>	G 158			



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G 158	<p>Continued From page 5</p> <p>did not contain documented evidence the MSW had attempted to contact the patient until 7/28/08, 7 working days from the physician's order. The MSW evaluated the patient on 8/11/08, per the patient's request. In the evaluation it stated the MSW would see the patient again on 8/24/08. There was no documented evidence the MSW had seen the patient after the 8/11/08 visit. Review of the patient's record on 12/16/08, disclosed no documentation that the agency had notified the physician of the late assessment on 8/11/08, and of the missed visit on 8/24/08. Additionally, Patient #9's POC dated 9/20/08, and signed by the physician on 10/31/08, stated the MSW was to perform a MSW evaluation. This was not done. On 12/17/08 at 11:00 AM, the Clinical Nurse Supervisor was interviewed via telephone. She stated the MSW did a MSW evaluation on 8/11/08, and it was determined the patient was going to follow up with her physician to treat her depression. She stated that due to "the computer", the MSW orders were "continued." The agency failed to notify the physician of the inability to have the MSW evaluate the patient until 25 days after the physician's order. Further, the agency failed to follow the 9/20/08 POC and provide a MSW evaluation.</p> <p>Patient #9's record contained a physician's order dated 7/30/08, that stated the nurse was to see the patient once a week for 8 weeks starting on 7/22 through 9/13/08. The record did not contain documented evidence the patient was seen by nursing staff on the week of 8/17 and 8/31/08. Patient #9's POC, dated 9/20/08, stated the nurse would see the patient every other week throughout the 8 week certification period. The patient was not seen by the nurse during weeks</p>	G 158			

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G 158	Continued From page 6 1-5 of the certification period. The record did not contain documented evidence that the agency had notified the physician of the missed visits. On 12/17/08 at 11:00 AM, the branch Clinical Nurse Supervisor was interviewed by telephone. She stated the patient was in another town during the 1st week through the 5th week of the certification. She confirmed the record did not contain documented evidence that the agency had notified the physician of the missed visits. The agency provided fewer visits than what the physician had ordered and therefore, the agency altered the POC and should have notified the physician.	G 158		
G 236	<b>484.48 CLINICAL RECORDS</b>  A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure medical records for 1 of 4 patients (#9), who were discharged from MSW services, included a MSW discharge summary. The findings include:  Patient #9 was a 58-year-old female with a SOC date of 7/28/07. She was admitted to the home health agency for medical management of her	G 236	G 236 and N 185 Discharge summary policy and process reviewed with staff. Staff education provided. Chart audits will be done per Joint Commission action plan.	Education in McCall was 1/8/09 and in Boise, 1/12 and 1/13/09. Audits start 1/26/09.

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G 236	Continued From page 7 CHF and renal disease. The patient's record contained a physicians order, dated 7/17/06, requesting a MSW consult. Patient #9's POC, dated 9/20/08, and signed by the physician on 10/31/08, stated the MSW was to perform a second MSW evaluation. The MSW saw the patient only once on 8/11/08. On 12/17/08 at 2:30 PM, the Clinical Nurse Specialist stated the patient was discharged from MSW services on 8/11/08. The Clinical Nurse Specialist reviewed the patient's record and she could not find a MSW discharge summary. The MSW failed to complete a discharge summary for Patient #9.	G 236			
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT  The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.  This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined that the agency failed to ensure patients received an initial visit within 48 hours of referral for 1 of 19 patients (#7), whose records were reviewed. This failure led to the potential of patient short term needs not being met in a timely manner. Findings include:  Patient #7 was an 88 year old female who was admitted to home health with the diagnoses of abnormality of gait and osteoarthritis. Her SOC was 12/1/08. PT was the only discipline providing services to the patient. The agency referral form, found in the record, documented the patient's referral date from her primary physician's office as 11/26/08. The initial visit was done on 12/1/08. The physical therapist who was assigned to admit the patient was interviewed on 12/15/08 at 4:00	G 332	G 332 Staff were educated regarding our policy on timelines: "Assessment, Implementation and Documentation" and also timelines required per regulation. Chart audits will be done as part of Joint Commission action plan.		Education in McCall was 1/8/09 and in Boise, 1/12 and 1/13/09. Audits start 1/26/09.

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G 332	<p>Continued From page 8</p> <p>PM. She stated that the patient's referral was received by the agency late in the day on 11/26/08. 11/27/08 was a holiday. The therapist then became ill and was not able to complete the admission in a timely manner. The patient was contacted by the therapist and agreed to an initial visit on 12/1/08. The therapist stated she assumed the physician's office was not open on 11/28/08, as well as 11/29 and 11/30/08 (the weekend), and did not notify the physician of the late admission.</p> <p>The agency did not ensure a timely initial visit to the patient.</p>	G 332			

Bureau of Facility Standards

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N 062	03.07021. ADMINISTRATOR  N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:  i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur.  This Rule is not met as evidenced by: Refer to Federal tag G144.	N 062	See Action Plan for G 144  <b>RECEIVED</b> <b>JAN 22 2009</b> <b>FACILITY STANDARDS</b>	
N 098	03.07024. SK. NSG. SERV.  N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  f. Informs the physician and other personnel of changes in the patient's condition and needs;  This Rule is not met as evidenced by: Please refer to federal Tag G144.	N 098	See Action Plan for G 144	
N 152	03.07030.01.PLAN OF CARE  N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing	N 152	See Action Plan for G 158	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

5DGZ11

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>137028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKES RMC HOME CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 WEST IDAHO BOISE, ID 83712</b>		
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N 152	Continued From page 1  services for that patient. Care follows the written plan of care and includes:  This Rule is not met as evidenced by: Refer to Federal tag G158.	N 152			
N 185	03.07031.CLINICAL REC.  N185 02. Contents. Clinical records must include:  k. A discharge summary.  This Rule is not met as evidenced by: Refer to Federal Tag G236.	N 185	See Action Plan for G 236		